HELP TEXT FOR LEVEL IV TRAUMA APPLICATION:

General information:

The application was placed on line with only the fill-in portions available for you to modify. To change from one form field (_____) to another, use the "tab" key on your keyboard, or click on each area. Check boxes (☐) can be changed be clicking on them so they are X'ed out (☒). You can type as much text as you like in the form field area; however, the length of visible text that will print out is limited to the size of the box around the text, or the end of that line. This was done purposely to avoid changing the layout and format of the document. If you can't see it, it won't print.

FAQ's:

Application Questions:

(1) Question: Many parts of the applications ask for additional narratives. How do I attach those sheets so TDH knows what question I'm answering?

> **(1) Answer**: The application has sections, indented headings and subheadings. At the beginning of each narrative simply include the name of the section, heading, and subheading associated with your narrative **OR** Restate the question at the top of the page.
>
> You will need to type out the section and one or two words to show what question the narrative is answering.
>
> > **Example**:
> > "Hospital Commitment: Administration" –this would show that the following text applies to the "Hospital Commitment" section and specifically addresses the administration's commitment to the program.

(2) Question: Should I attach documents that already exist in lieu of typing them over to answer any question? How do I attach them?

> **(2) Answer:** Yes. In fact, we encourage it. The more information you can provide, the easier it is for TDH to understand your facility and trauma program. Attach the documents the same way you would original, typed narratives. Use the same reference technique described in **(1) Answer** above.

(3) Question: Whom do I call for information or guidance while filling the application?

> **(3) Answer:** For *Technical* Difficulties call Jeff Hummel (512) 834-6700 x6684
> For content or clarification of questions call D. Parkhill (512) 834-6700 x2348
> **Or**
> Gina Pickard (512) 834-6700 x2457
> **Or**
> Kim Petty (512) 834-6700 x 2346

Bureau of Emergency Management
1100 West 49th Street
Austin, Texas 78756-3199
512/834-6700

Basic (Level IV) Trauma Facility Designation
Application

General Information:

Date:
Hospital Name:
Address:
County: TSA: _____

☐ Initial Survey
☐ Re-designation Survey
Expiration Date:
Number of Licensed Beds: _____

Hospital Information:

Contact Person:
Title/Position:
Phone Number(s): ( ) - ( ) - ( ) -
Fax Number(s): ( ) - ( ) - ( ) -

_____
Typed name of Chief Executive Officer or authorized person

Signature: _____ Date:
Title: _____
Phone: (___) ___-____

Describe your hospital, including tax status, governance and affiliations. Define your hospital=s role in the community, including regional trauma system development and implementation. Include applicable organizational charts.

attach additional sheets if necessary

Hospital Commitment:

Is there a resolution supporting the trauma center signed by the hospital=s governing body and dated within the past three years? ☐ Yes ☐ No
If "Yes" include with application.

Is there a resolution supporting the trauma center signed by the hospital=s medical staff and dated within the past three years? ☐ Yes ☐ No
If "Yes", include with application.

Is there specific budgetary support for the trauma service?
☐ Yes ☐ No

If "Yes" specify	

Describe the commitment of your administration to trauma care, in detail.

Attach additional sheets if necessary

Pre-Hospital System

Who has authority over EMS in your system (city, county, other)?	??_____

Describe the EMS governing body, including medical leadership.

Attach additional sheets if necessary

What type of public access to EMS is used in your community (check all that apply)?
☐ 911 ☐ Enhanced 911 ☐ Other (define): _____

How are EMS personnel dispatched to the scene of an injury (check all that apply)?
☐ EMS Center or 911 Center ☐ Fire Department ☐ Law Enforcement Agency
☐ Other (define):_____

Identify the initial responders to injury scenes in your catchment's area (check all that apply):

Agency	Basic Level	Advanced Level
EMS	☐	☐
Fire	☐	☐
First Responder	☐	☐
Police	☐	☐
Other (specify)	☐	☐

Define the "Air Medical" support services available in your area.

Attach additional sheets if necessary

Does your hospital have a designated heli-pad? ☐ Yes ☐ No

If "No", describe location, access and protocols for air transport.

Does your trauma center serve as a base station for EMS operations and provide online medical control?

☐ Yes ☐ No

Detail participation in pre-hospital training and pre-hospital performance improvement.

Attach additional sheets if necessary

Describe participation in your regional disaster plan.

Attach additional sheets if necessary

Trauma Program

Physician Director: _____

Provide a narrative job description for your Trauma Medical Director.

Describe the trauma service including how the Trauma Medical Director oversees all aspects of the multi-disciplinary care, from the time of injury through discharge and involvement in the Performance Improvement process.

Attach a separate sheet if necessary

Trauma Coordinator:

Provide a narrative job description for your Trauma Coordinator.

Is Trauma Coordinator a full-time position? ☐ Yes ☐ No

If "No", detail the percentage of time spent performing trauma coordinator duties and describe other duties of this position.

_____ %	

Describe the administrative reporting structure and attach an organizational chart that includes the trauma program

Attach addtional sheets if necessary

Trauma Response:

Include copies of the following policies/protocols:

- Trauma Team Activation Policy
- Roles and Responsibilities of the Trauma Team
- Resuscitation Protocol
- Trauma Standards of Care (send a sample and a table of contents)

Trauma Service Statistical Data:

Total number of ED visits for reporting year, including DOA and DIE (provide month/year to month/year dates used in completing application

Reporting Dates (MM/YY) to MM/YY) _____ to _____

Total number of trauma-related ED visits: _____

Total number of Hospital Admits (all categories): _____

Total number of Physicians on staff for entire hospital: _____

Disposition of Trauma Patients	
ED to OR	0
ED to ICU	0
ED to Floor	0
Deaths	0
Total	0

Number of Critical Trauma Transfers	Air	Ground	Total
In	0	0	0
Out	0	0	0

Do you have written agreements for transfer of trauma patients out of your facility for acute injury management? (Have agreements available on-site for examination.) ☐ Yes ☐ No

List receiving hospitals, their level of trauma designation and distance from your facility.

Hospital	Trauma Designation	Distance (miles)
	??_____	
	??_____	
	??_____	
	??_____	
	??_____	

Do you have Transfer Protocols? (Have protocols available on-site for examination.) ☐ Yes ☐ No

Do you have Triage Transfer Criteria? If "Yes", include with application. ☐ Yes ☐ No

Trauma Bypass/Divert:

Do you have a bypass or divert protocol? ☐ Yes ☐ No
If "Yes", include with application.
If "Yes" who has the authority to issue/cancel a diversion?_____

Has your facility gone on trauma bypass/divert during the previous year? ☐ Yes ☐ No
If "Yes", complete "Trauma Bypass/Divert Occurrences" Table, located at the end of the document.

Hospital Facilities

Emergency Department:

List Emergency Department physicians serving on the Trauma Panel in Table C (located at end of this document). Include with application.

Describe your ED nursing staffing pattern. Explain how you ensure an adequate nurse to patient ratio.

Nursing staff certifications:

Total number of staff	??_____	Explain here
Percent with TNCC	??____%	
Percent with PALS	??____%	
Percent with ENPC	??____%	
Percent with ACLS	??____%	
Percent with CEN	??____%	

Include a copy of your current ED trauma flow sheet.

Describe how pre-hospital personnel access your Emergency Department.

Attach additional sheets if necessary

What is the average lead time (in minutes) from ED communication?	
By ground?	
By air?	

Radiology / Ultrasound:

Do you have resuscitation and monitoring equipment available in the radiology suite?
☐ Yes ☐ No

Who accompanies and monitors the trauma patient to the radiology suite? _____

Is there a 24-hour CT technician available in-hospital?
☐ Yes ☐ No

If "No", is there a performance improvement program which reviews timeliness of CT response?
☐ Yes ☐ No

Who interprets the radiographs after hours? _____

Is teleradiography available to augment the initial interpretations by a non-radiologist?
☐ Yes ☐ No

What is available at your facility?
CT ☐
MRI ☐
Radiology ☐

Operating Room:

Under what circumstances do you take trauma patients to the operating room?
(Discuss how your facility meets Level III criteria in these situations).

Attach additional sheets if necessary

Clinical Laboratory:

Describe your source of blood products and include the number of units of O negative your facility has on hand and how long the units are maintained.	
Amt of O Neg:	Briefly describe your source

Is there a massive transfusion protocol to facilitate blood component therapy? ☐ Yes ☐ No
(Have protocol available on-site for examination.)

Do you have uncross-matched blood immediately available? ☐ Yes ☐ No

If "Yes", define mechanism.

What is the average turn around time, in minutes, for an emergency?

Type specific blood _____ minutes
Full crossed-matched blood _____ minutes

<u>Does your facility have:</u>

Micro-sampling capabilities for children ☐ Yes ☐ No
Blood Gas ☐ Yes ☐ No
Other lab ☐ Yes ☐ No
Trauma panel ☐ Yes ☐ No
H&H ☐ Yes ☐ No
Is there 24-hour staffing? ☐ Yes ☐ No

Burn Patients:

Describe your standard of care, burn resuscitation protocol, transfer triage criteria, and transfer agreements. (Have protocol and agreements available on-site for examination.)
Attach additional sheets if necessary

Total number of burn patients transferred for acute care during the last reporting year: _____

Total number of burn patients admitted to your facility during the last reporting year:_____

Spinal Cord Injuries:

Describe your standard of care, spinal cord injury protocol, transfer triage criteria and transfer agreements. (Have protocol and agreements available on-site for examination.)
Attach additional sheets if necessary

Total number of spinal cord injuries treated at your facility during the last reporting year: _____

Total number of patients with acute spinal cord injury transferred during the last reporting year:_____

Pediatric Trauma:

Describe your standard of care, organized pediatric resuscitation protocol, pediatric specific equipment, transfer triage criteria and transfer agreements. (Have protocol and agreements available on-site for examination.)
Attach additional sheets if necessary

Performance Improvement (PI)

Do not send any performance improvement minutes or patient specific information! These should be available on-site at the time of your survey.

Performance Improvement (PI) Program:

Describe your PI program, including how issues are identified, tracked and who is responsible for supervision of both the system and peer review issues. List all members of any multi-disciplinary trauma committees and the frequency of meetings held. Describe the Physician Director=s involvement. (Have PI reports available on-site for examination.)

Include blank copies of all PI forms.

Explain how trauma PI has improved trauma patient care (demonstrate trends, " loop closure" and process improvement).
Attach additional sheets if necessary

Trauma Registry:

Total numbers of months/years of trauma registry data complete for review?	Months	Years

Date registry was established: _____

What registry program does your facility use? _____
Who abstracts data from the charts for entry into the registry? _____
What type of trauma registry training is available for this position? _____

Describe the criteria for patient entry into the trauma registry. Include a copy of your Data Quality Report Form.
Attach additional sheets if necessary

Total number of deaths categorized as preventable: _____
Total number of deaths categorized as non-preventable: _____
Total number of deaths categorized as possibly preventable: _____

Educational Activities / Outreach Programs

Describe trauma education programs provided for your physicians, nurses, staff and pre-hospital personnel
attach additional sheets if needed

Describe trauma orientation process and skills evaluation for nurses in the emergency Department
attach additional sheets if needed

Is there hospital funding for physician, nursing or EMS trauma education? ☐ Yes ☐ No
If "yes", describe.

attach additional sheets if needed

Describe your injury prevention/public trauma education programs, including Regional Advisory Council (RAC) involvement and how the effectiveness of your programs is evaluated.
attach additional sheets if needed

Signature (Trauma Coordinator) Signature (Physician Director)

Date Date

PRE-REVIEW DOCUMENT CHECKLIST

(To be completed by the hospital)

I. General Information

- ☐ Hospital's Governing Body Resolution
- ☐ Medical Staff Resolution

II. Trauma Service

- ☐ CV: Trauma Physician Director
- ☐ CV: Trauma Coordinator
- ☐ Job Description: Trauma Physician Director (include description of authority)
- ☐ Job Description: Trauma Coordinator
- ☐ Organizational Chart: Trauma Service
- ☐ Organizational Chart: Trauma Coordinator
- ☐ Chart A completed Go to it Click here

III. Hospital Facilities

- ☐ CV: Emergency Medicine representative to the Trauma Program
- ☐ Chart B: Education of Nursing Personnel Go to it Click here
- ☐ Chart C: Education of Medical Personnel Go to it Click here
- ☐ Trauma Flow Sheet (ED)
- ☐ Trauma Team Activation Protocols
- ☐ Roles and Responsibilities of the Trauma Team
- ☐ Resuscitation Protocol
- ☐ Trauma Standards of Care (send a sample and a table of contents)

IV. Performance Improvement

- ☐ Trauma PI Audit Form

V. Criteria Checklist

- ☐ Check list completed

This list is provided to assist you in assuring that your pre-review application is COMPLETE.

CHART A - EMERGENCY SECTION

1. Physician Directors, Emergency Department

Name:_____

Board Certification: _____

ATLS Course completion date:_____

ACLS Course completion date: _____

Pediatric Advanced Life Support course completion date: _____

Number of trauma CME hours in last 12 months:_____

2.Trauma Nurse Coordinator

Name: _____

Is this a full-time position? ☐ Yes ☐ No

ACLS Course completion date: _____

Pediatric Advanced Life Support course completion date: _____

TNCC Course completion date: _____

Other specialty certification(s): _____

Number of trauma CE hours in last 12 months: _____

CHART B - EDUCATION/CERTIFICATION OF NURSING PERSONNEL

Complete the chart; include only nursing personnel who cover the Emergency Department.

NAME	LICENSURE (RN/LVN)		COURSE COMPLETION DATES				NUMBER OF *TRAUMA* CE HOURS IN LAST 12 MONTHS
	RN	LVN	ACLS	PALS	TNCC	OTHER	
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					

CHART C - EDUCATION/CERTIFICATION OF MEDICAL PERSONNEL

Complete the chart; include only physicians and physician assistants who cover the Emergency Department.

Name	Residency		Board Certified		ATLS		Number of trauma CME hours in last 3 years-hours	Frequency of shifts/call per month	
	Where	When Completed	Type (abbr.)	Year	Check if Instructor	Expiration (mm/yy)		**Freq**	**# calls**
				1990	☐				
				1990	☐				
				1990	☐				
				1990	☐				
				1990	☐				
				1990	☐				
				1990	☐				
				1990	☐				
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